Buried under a pile of papers I found this response by Dr Gilbert to a request by Dr Blake Waterhouse, CEO of Straub Clinic & Hospital. It was written by Fred in 1991 in his broad-stroked and nearly indecipherable longhand, asking questions for us all to answer:

Suggestions for 1992 Service and Cost Improvements

Fred I. Gilbert, Jr, MD

Blake: We are deafened by cries for reform and restructuring of the manner in which medicine is practiced. From rich and poor, radicals and conservatives, big business and small business. Unfortunately, they are more right than wrong. Our system at Straub like most everywhere is upside-down. We need more primary care physicians (and nurse practitioners), fewer specialists, better integration and continuity of care—in short, a greatly revamped, more rational (capitation) system of health care. We need to think about it, talk about it, write about it, and most of all, *do it!*

What is the best way to reconsider, broadly, how to improve the process, cost, and outcome of patient care? One way is to sit down with a modern-day Osler who has the skill, scope, humanness, thoughtfulness, and knowledge of the best of the general internists, but who also understands and is willing to re-examine new organization, methods, and technology without being bound to the past.

Priorities for the next decade will be to contain costs, increase quality, involve patients in the decision, put new technology in its proper place, increase efficiency—all the while maintaining or improving personal relationships with our patients, the final common pathway.

General internists.—Two-thirds say they cannot see any more patients.

Do we care for the patients we see in the best way?

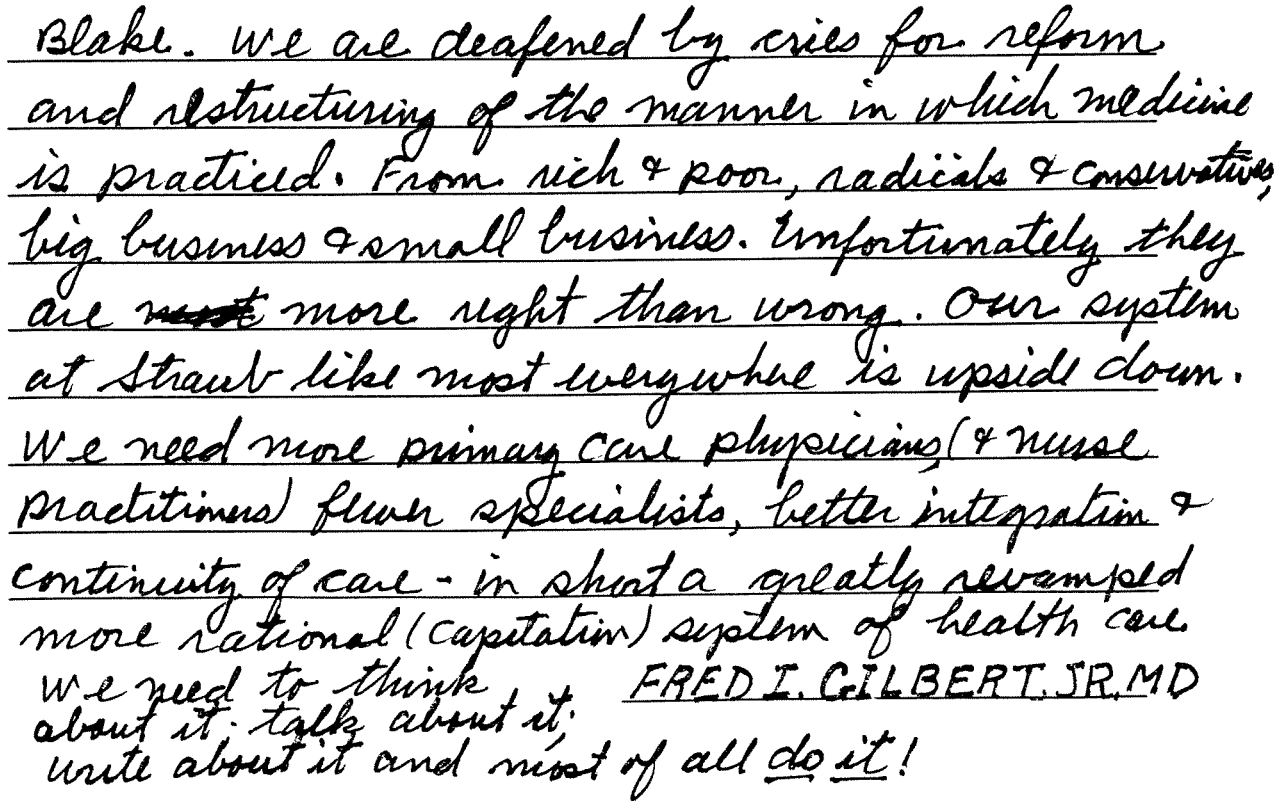
How about the care of those who do not come to see us?

Should there be a reorganization of the tasks now done by the general internist? Is he or she trying to do too much? or too little by referring too many patients?

Health care personnel.—Are we using them sufficiently? efficiently?

Could a nurse practitioner (under the guidance of a physician and with the help of a computer) do periodic examinations, provide periodic review and updates of needs (Pap tests, prostate, immunization, pneumovax)?

Could a trained colonoscopist do routine and F/U colon exams?



Could a trained nurse practitioner run specialty clinics for family planning, gout, cardiac rehabilitation, diabetes, hypertension?

When internists are too busy, are they doing the wrong things?

Is the internist freed up to do the things he or she is most uniquely trained for and capable of?

Should the same physician be expert at ICU and periodic examinations?

What should medical schools train an internist to be?

Does the responsibility of the medical school include consideration of innovative ways to deliver health care with different classes of personnel, or does it stop at training a *good internist*?

Research.—Bench, clinical, outcomes should be part of large, expensive, randomized, double-blind crossover studies?

Should every physician be doing continual research, daily? What kind?

How much training in epidemiology and statistics is needed?

What is the function of the medical school in fostering it?

Who pays for it? Should it be part of every practice?

Medical records.—Are POMRs sufficient?

Should the record be entirely electronic within a decade or so?

Should every medical student be required to have and use a computer?

Should it be possible to monitor the mix, cost, process, and outcome of every patient of every doctor, with instant peer-review and inter-physician comparison for single patients and groups of patients?

Would that be good or bad, frightening or reassuring?

"Everything is changed except the way we think."
(Einstein at the dropping of the atomic bomb)